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ABSTRACT

The value of early identification of sexually aberrant behaviors and intervention with sexually deviant minors is obvious from a community safety perspective. Early intervention also appears to have value from the offender's perspective. A research review revealed several common themes with implications for both assessment and treatment. Most theoreticians agree that the onset of deviant sexual behavior usually begins around puberty; that such behaviors tend to be chronic if there is not effective intervention; and that juvenile sex offenders tend to be loners and underachievers with low self-esteem and poor social skills. Abusive family histories, the development of cognitive distortions, male socialization patterns, and organic biomedical problems have all been associated with sexually deviant behavior. A major assessment task is to determine whether the behavior is situational or symptomatic of unresolved issues in psychosexual development. Models helpful in assessing juvenile perpetrators have been developed by Groth and Loredo, the Sexual Behavior Clinic, and the University of Washington's Juvenile Sex Offender Program (JSOP). Various theoretical orientations have their own specialized treatment recommendations. Psychodynamic, biomedical, social psychology, and social learning perspectives all contribute to knowledge about how to help the sexually deviant youth. (A typology of adolescent sexual offenders, a chart of preconditions for sexual abuse, various sex offender program forms, juvenile sex offender decision criteria and other assessment information from the JSOP, and guidelines for assessing sexual abuse in juvenile cases are appended.) (NB)

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ADOLESCENT PERPETRATOR TREATMENT PROGRAMS: ASSESSMENT ISSUES

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Working paper by Joan M. Abbey, M.S.W. Candidate, University of Michigan for Maxey Boy's Training School, Michigan Department of Social Services. March, 1987.

ADOLESCENT PERPETRATOR TREATMENT PROGRAMS: ASSESSMENT ISSUES

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INTRODUCTION

Statement of Problem.

Public concern regarding the issue of sexual assault over the past two decades was preceded by an increased interest in assessing and treating sex offenders by mental health professionals. This interest and the research it has spurred, results from the growing realization that without effective perpetrator intervention, all other means of dealing with the problem of sexual assault are analogous to closing the barn door after the horse has escaped. There has been a burgeoning body of literature on victimology and a growth in research focused on adult perpetrators. However, professionals have been slower to recognize the importance of early identification and treatment of the juvenile perpetrator.

Evaluation and treatment of adolescent perpetrators was not undertaken in a systematic or comprehensive fashion until the fall of 1975. At that time the University of Washington School of Medicine's Adolescent Clinic was asked to evaluate and treat a group of adolescent offenders from around the state.(1) Since then the identification and treatment of adolescent perpetrators has been evolving into a highly specialized discipline. This new discipline includes a variety of psychotherapuetic, cognitive, and behavioral elements, as well as incorporating educational components. Due to the relatively youth of this field, clear models of etiology are unavailable to practitioners. Nonetheless, as Monastersky and Smith point out "a sound paradigm is essential in assessing and planning intervention strategies."(2) While the tendency to adopt adult models which may be inappropriate for juvenile perpetrators is a concern, much can also be learned from adult models and research on adult perpetrators.

It is the purpose of this paper to present current research and theoretical perspectives as to the causes of sexually deviant behavior. Any inferences which can be drawn from the research as to assessment and treatment methods will also be introduced. Prior to outlining the theories of why some individuals engage in sexually deviant behaviors, a definition of sexual deviance will be proffered, along with several suggested classifications of adolescent perpetrators. Further, this document will include

assessment guidelines, as well as the assessment scales most frequently cited in the sexual assault literature. This information is set forth with the conviction that it will assist the staff at Maxey Boys Training School, Michigan Department of Social Services in conceptualizing an assessment and treatment model suited to their client population and task environment constraints.

Definitions and Classifications.

The Adolescent Perpetrator Network has adopted the following definitions to avoid confusion among professionals working with adolescent perpetrators.

1. Adolescent Perpetrator: A youth, from puberty to the legal age of majority committing an act.
2. Adolescent Sexual Offender: A youth, from puberty to the legal age of majority, committing any sexual interaction with a person of any age: against the victim's will, without consent, or in an aggressive, exploitative, or threatening manner.
3. Adolescent Molester: An adolescent sexual offender engaging in sexual interactions with a significantly younger, prepubescent victim.(3)

The term used by the DSM III to categorize sex offenders is paraphilia, which means attraction to deviance. Paraphilia or sexual deviation syndrome is characterized by, 1) recurrent fantasies about engaging in unconventional sexual activities, 2) these erotic fantasies are accompanied by intense erotic cravings, and 3) stereotyped behaviors in response to the erotic cravings. The DSM III lists nine major subcategories of paraphilia which are as follows: 1) Pedophilia, 2) Exhibitionism, 3) Transvestism, 4) Voyeurism, 5) Zoophilia, 6) Fetishism, 7) Erotic Sadism, 8) Erotic Masochism, and 9) Other (this category includes compulsive rape).(4)

It should be noted that the paraphiliac syndromes are not mutually exclusive, and that all paraphiliac syndromes are not one in the same. Further, sexual deviance is not confined to a particular social class or ethnic group. Although most identified offenders are adult males, it would be wrong to assume that only males commit sex crimes. "Females also commit sexual assault, but ... such offenses are not visible nor, where discovered

taken very seriously."(5) Therefore, there is little research available regarding the female sex offender.

As previously noted, in the past little attention was given to the adolescent perpetrator, particularly in relationship to "what is perhaps the most common form of child sexual abuse: sexual victimization of the child by a teenager or adolescent."(6) In more than 56% of the child molestation cases referred to the Child Sexual Abuse Victim Assistance Project of Children's Hospital in Washington, D.C., the offender was under the age of 18, with the majority falling between the 14 to 16 age range."(7) While accurate figures concerning the number of sexual offenses committed by adolescents are not available the National Crime Survey indicates that adolescent males committed 21 percent of forcible rapes in 1979. "That amounts to 200 forcible rapes per 100,000 adolescent males."(8) The National Crime Survey does not measure the number of youth involved in other sex crimes such as, "date" rape, voyeurism, and exhibitionism. However, there is agreement among researchers and practitioners that adolescents are involved in a large number of diverse sex offenses including burglaries with sexual motivations.(9)

A few researchers and practitioners have developed classification schemes to aid in assessing and treating adolescent perpetrators. Marasek reports that Shoor (1966), Groth (1977), and others have subdivided adolescent perpetrators into two categories with differing prognoses. First, is the aggressive perpetrator who employs violent coercion and demonstrates little remorse. This type of perpetrator has a worse prognosis than the second type who uses persuasion or bribery to entice the younger child to gratify him.(10) Michael O'Brien's (Director, PHASE) classification scheme covers a variety of behaviors related to specific sets of intrapsychic, family and offense behavior factors. (See Appendix I.) Caution needs to be used in classifying juvenile perpetrators into set typologies, as their is sufficient research which suggests that the nature of an offender's behavior may change over time. The exercise of caution is also called for because of the unresolved issue of stigmatizing minors by labeling them.

The Juvenile Sex Offender Program (JSOP) at the University of Washington utilizes a continuum to characterize offending behavior. This is perhaps the most practical way to categorize juvenile perpetrators.

Sexual Offense Continuum

Nonaggressive hands-off
Exposure, voyeurism, obscene phone calls and letters, masturbating with women's underwear

Aggressive hands-off
Breaking and entering for the purpose of stealing women's underwear, any activity from first category, that increases victim proximity

Nonaggressive hands-on
Fondling, oral-genital contact, may include penetration, uses authority as older person to gain access to victim

Aggressive hands-on
Fondling, oral-genital contact, penetration, uses force, weapon or threatens to, doesn't stop with victim distress

The above continuum is used by JSOP to help determine the appropriate treatment setting for a given juvenile perpetrator. "Adolescent sex offenders who engage in non aggressive acts may be considered for treatment in the community. Aggressive sexual offenders are referred to institutional settings."(11)

There is an obvious "need to establish a comprehensive typology of juvenile sex offending behavior, a typology that provides a theoretically sound basis for understanding the antecedent and consequent events surrounding the offending behavior."(12) Lacking a comprehensive typology or unifying theory to use as a guide in program development Maxey Boys Training School will have to devise their own classification scheme based upon their client populations' attributes, task environment elements, as well as current research and theory. Hence, the following sections of this paper present a review of the literature regarding research on sex offending behavior, and prevailing theories as to the causes of deviant sexual behavior.

RESEARCH AND THEORETICAL PERSPECTIVES

RESEARCH

The value of early identification of sexually aberrant behaviors and intervention with minors is obvious from a community safety perspective. Early intervention also appears to have value from the offender's perspective. Knopp relates a statement made by a 17 year old youth (who had molested a seven year old girl) upon his release from Hennepin County Home School's Sexual Therapy Program: "If I hadn't been in this program, I would have kept on doing what I was doing. It's like drugs. After you lose the effect of one drug, you go on to a different one. I'm pretty sure I would have gone up to rape."(13)

Unfortunately in the past the adolescent perpetrator was diagnosed as having "Adolescent Adjustment Reaction" or his behavior was written off as curiosity or experimentation. Longo warns against the dangers of not taking adolescent offenses seriously. He reports that in a study of convicted sex offenders he found 62% engaged in repetitive voyeurism or exhibitionism as juveniles.(14) Furthermore, one out of three offenders studied show evidence of progression from non-violent sex crimes during adolescence to more serious crimes as adults. He found a significant number of sexual aggressors with lengthy histories of sex behaviors, such as exhibitionism, voyuerism, obscene telephone calls, transvestism, and fetishism. Most of these individuals began exhibiting deviant behaviors in childhood or early adolescence.(15) In general Longo suggests that non-contact or "nuisance" offenses committed by adolescents be recognized as symptomatic behaviors which can escalate into serious problems.

Commensurate with the problem of escalation is the chronic nature of these crimes. Groth, Longo, and McFadin in a study of 137 convicted sex offenders found that on average they had committed two to five times as many sex crimes then they were apprehended for. The subjects were men who ranged in age from 16 to 57. The modal age for rapists at the time of their first offense was 16. Child molesters were found to be bimodal, in that the modal age for a first offense was 13 and 35.(16) The researchers caution that these self-reported incidence figures are conservative, due to the fact that sex offenders tend to minimize their wrongdoing and to misperceive

their own behavior and that of their victims. When one realizes the chronic and escalating nature of sex crimes, the importance of early identification and intervention with adolescent sex offenders becomes apparent.

It is interesting to note that in the same study Groth (et. al.) found rapists were more prone to juvenile voyeurism (22%) than child molesters. Whereas child molesters had a higher incidence rate (24%) for repetitive exhibitonism as juveniles. Compulsive masturbatory behavior as a juvenile was present more in adult convicted child molesters than rapists.(17)

More noteworthy however, are recent studies by Abel, Mittleman, and Becker, of the New York State Psychiatric Institute. The information was collected under a strict system of confidentiality and the subjects were sex offenders who **volunteered** for outpatient programs in two cities. Conducted over a 12 year period these studies have produced some new and startling data.(18) First, their data supports the view of Longo and others that offenses increase as the youth becomes an adult. "Abel (1984) reports that of the paraphilias, these offenders under the age of 18 commit an average of 6.75 crimes per offender, while adults committing similar crimes commit an average 380 crimes per offender."(19) Second, the research also indicated the scope of underreporting of sex offenses, especially child molestation. Data on 232 child molesters whose victims were younger than 14 years old revealed an average of 238 attempted and 167 completed child molestations each. "Their total number of victims was 17,585."(20) Third, Abel et. al. found that almost 50% of the study's subjects were involved in number of paraphilias. For instance, more than 50% of the rapists were involved with child molestation and approximately 17% of child molesters were involved in rape. Finally, the data also supports past research which has demonstrated that the onset of deviant sexual arousal patterns begins in adolescence.(21)

THEORETICAL PERSPECTIVES

Psychodynamic Theory.

Psychodynamic theory assumes that hetrosexuality alone is natural and that any other sexual orientation is pathological. These pathologies occur when development goes awry.as a result of traumatic early life

experiences. Sexual trauma may be experienced passively via witnessing adult sexual activity or being overexposed to sexual talk and materials. Whereas active trauma is experienced directly by the child in the form of sexual abuse. Sexual deviations are considered to be a reflection of unconscious psychological conflicts created by these traumatizing experiences.

Psychodynamic constructs are at the heart of Nicholas Groth's description of sexual deviants. According to Groth "the majority of rapists were once victims of sexual abuse ... as a chronic behavior pattern it [sexual assault] appears to have its roots in the sexual abuse experienced by the offender at a critical time during his formative years. The subsequent interference with his psychosexual maturation and the resulting defects in his personality compound to make him a high risk for committing sexual assault."(22) In conducting research on sex offenders Longo determined that a significant number had been victims of sexual abuse or experienced sexual trauma prior to the onset of puberty. They found the mean age for a first sexual contact was 9.5 and the mean age for first experiencing sexual intercourse was 11.9, for a total of 47% being molested before the age of 12.(23) The unresolved trauma experienced by offenders causes them to engage in a compulsive re-enactment of the experience in an attempt to gain mastery and control over it.(24) As Steele points out, "In sexual abuse, too, we see some rather literal, direct repetitions of childhood experience."(25) Abel (1985) reports that one noticeable difference between males who are sexually abused and become offenders and those abused who do not become offenders is frequency of victimization. Abusers have experienced multiple victimizations.(26) Groth postulates that males are " 'Socialized to get even' and 'fight their own battles' the male victim is likely to identify with the role of the aggressor rather than to empathize with the role of the victim."(27) Thus, one way the sexually victimized young male tries to combat the helplessness of his victimization experience is to become the more powerful victimizer.

Biomedical Theory.

Biomedical theory postulates that sexually deviant urges are more apt to occur when certain biological abnormalities are present.(28) These theoreticians argue that biological pathologies, such as structural brain damage, hormonal dysfunctions, genetic anomalies or electrical disturbances

of the brain may play a role in predisposing certain individuals to commit sex crimes.(29) It is suggested that sexually deviant behaviors may simply be a manifestation of a psychiatric syndrome such as, schizophrenia or maniac depression. In other cases the behavior may result from alcohol/drug induced psychosis or mental retardation.(30) However, it should be noted that retarded individuals are the exception rather than the rule amongst sex offenders and that the majority of retarded offenders fall in the mild to borderline range.(31)

Berlin relates a study wherein a "variety of laboratory tests were performed on a group of paraphaliac patients, there appeared to be a very high frequency of biological pathologies in these patients." Included in the pathologies discovered by the researchers were structural brain damage, hormonal abnormalities, electroencephalographic dysfunctions, and chromosomal anomalies.(32)

Social Psychology.

Social psychological theorists argue that a combination of intrapsychic and cultural factors are at work in predisposing an individual to engage in deviant sexual behavior. This paper will look at two theories which fall under the rubric of social psychology.

Daum is representative of advocates of the "situational" perspective. According to Daum "an exceedingly high number of rapes and sexual impositions of younger children take place when a sexually inexperienced boy, who has just reached puberty is placed in charge of smaller boys or girls."(33) The deviant behavior results from the youth becoming over-stimulated whilst engaging in caretaking activities such as, bathing and dressing. As a result of the adolescent's sexual inexperience he may lack sufficient control.(34) Situational theory suggests that society contributes to the problem in several ways. First, parents and others fail to provide the adolescent with guidance on how to handle his sexual feelings and thoughts. Second, society only serves to titillate the adolescent via the print and broadcast media. "Network television stimulates sexual curiosity, but rarely is such curiosity satisfied."(35) Finally, the unprepared adolescent is placed in stimulating situations without proper supervision

Finkelhor's four factor model is based on his analysis of the research

literature. He determined that most theoretical approaches to pedophilia looked at four factors, which he categorizes as elements that are causative. His model goes beyond looking at types, such as fixated or regressive, but looks at components instead.(36) The concept of components allows this model the flexibility to be applied to some other forms of paraphilia.

The first factor is emotional congruence, or why would a person find deviant sexual activity to be emotionally gratifying? The second element is sexual arousal, or why would anyone find a child and/or other unconventional stimuli arousing? Blockage is the third component. Blockage refers to the person's inability to be sexually or emotionally gratified from "normal" sources. The fourth factor is disinhibition, or why isn't the offender deterred from the behavior by social restraints and normative inhibitions?(37) Incorporating theory from psychodynamic, social learning, and feminist perspectives this model sets forth a number of preconditions which may be applicable in each category. Further, the explanation for a precondition may occur at either the individual or social/cultural level. (See Appendix II.)

In assessing sex offenders Finkelhor suggests that the practitioner focus on all these factors at each level. For instance, with emotional congruence, the clinician should identify what needs are being met by the behavior and how these needs may be met in more appropriate ways. In the area of sexual arousal the focus should be on what interests lead to arousal and how to distinguish or reorient arousal patterns. The task of assessment relative to blockage is to discover other methods for the perpetrator to get his needs met, or how to overcome his inability to be gratified in more appropriate ways (i.e. teaching social skills). For the fourth factor of disinhibition, assessment and treatment must focus on discovering and confronting the perpetrator regarding his lack of inhibitions and the teaching of controls.(38)

Note that unlike the other theoreticians presented in this section Finkelhor is not a practitioner, but an academic who views himself "as a gadfly, who tries to separate the myth from the reality by research."(39) He cautions practitioners not to let new myths replace old ones. Several evolving "myths" that are worth inclusion in this paper are presented below.(40)

MYTH	REALITY
Victims become victimizers.	Less than 1% of offenders apprehended, studies of perpetrators in jail not indicative of all abusers. Most abusers male and most victims female, thus men abuse because of cultural conditioning to respond to offense by victimizing others.
Offending behavior result of psycho-pathology, or dysfunctional family.	Influence of male sexual socialization Limited opportunities to get emotional needs met, one exception is sexual relationships. Conditioned to believe appropriate sex partner is weak, younger, and smaller. Exemption of men from child-rearing results in not being tuned into children's needs.

Social Learning.

Abel proposes a social learning model to explain the acquisition of and maintenance of deviant sexual behavior. Such behavior he posits can be learned through a number of modes. For example, aggressive behavior may be learned by an adolescent perpetrator exposed to family violence. Abel reports that a "survey of 131 adult sex offenders seen at the Sexual Behavior Clinic indicates that 89.3% had been hit as children by their parents and 42% had parents who fought violently."(41) Thus, Abel argues being the victim of physical or sexual aggression may also predispose an individual to model that behavior. A second factor in Abel's social learning approach "relates to the recall of the initial deviant sex act during masturbation-orgasm activities. Pairing or bonding of the deviant sexual fantasy and sexual excitement during masturbatory activity gives the fantasy greater erotic power.(Abel, Becker & Skinner, 1983; Blanchard & Abel, 1975)"(42) The third component is the person's ability to relate to other members of society. "If an adolescent has grown up in a home without good role models for functional, social, and assertive behavior, he will have difficulty relating to his peer group on a functional level."(43)

According to Abel, in addition to abusive factors in their histories, sex offenders have deviant thinking patterns. Criminal thinking patterns or errors have a direct influence on the development and maintenance of deviant sexual thoughts and fantasies. Critical to the development of deviant sexual interest is what the offender says to himself about his behavior. Abel advises that this distortion in thinking makes it easier for the adolescent to do away with morals and values that would otherwise result in feelings of guilt or disgust with their own deviant thoughts and fantasies. These cognitive distortions are a result of the offenders limited sexual knowledge, a lack of empathy for the victim, misunderstanding or little understanding of sexual values, and faulty perceptions about his own victimization experiences.(44) "When thinking errors are present and fantasies occur, which are then reinforced by masturbatory activity, a very powerful learning process takes place."(45)

ASSESSMENT

Assessment is crucial in determining differential diagnoses, formulating appropriate treatment plans and evaluating treatment outcomes. Of course, it goes without saying that assessment is an on-going process and not limited to one or two clinical interviews. Practioners approach assessment in different ways dependant upon their theoretical orientation and the type of program (setting and client attributes) they are operating. However, two assessment models are consistently cited in the literature, they are Nicholas Groth's approach and the University of Washington's JSOP program. The reader will note that the techniques used by Abel and his colleagues at the Sexual Behavior Clinic are also included as it is felt that their approach adds considerably to the "science" of assessing juvenile perpetrators.

Groth & Loredo.

There are three realms of behavior practitioners must discriminate between in assessing a juvenile perpetrator. The first is situational, or is this an inappropriate, yet normative sex act? A second determination is whether or not the behavior is solitary sexual activity of a non-aggressive nature. The third realm is sexually assaultive behavior which poses harm to others. Groth considers the first to be a social matter, the second to be a clinical matter, and the third to be both a clinical and legal matter.(46) In evaluating any sexual activity Groth and Loredo suggest that eight basic issues be addressed.

1. What is the age relationship between the individuals involved? Are they age mates, or is there a significant discrepancy between their ages? The greater the age discrepancy the more significant the behavior. Especially "ominous" are incidents where an older adolescent engages a prepubertal child. Such age differences may suggest the extent to which sociosexual interests are confined and the adolescent's difficulty in relating to peers. Further, a significant age difference may be indicative of any symbolic importance regarding the child towards whom the advances were made.(47)

2. What is the social relationship between the persons involved? Are they relatives, close friends, casual acquaintances, or total strangers? Victims at either extreme, such as, family members or strangers are viewed

as inappropriate. Intrafamily sexual activity raises the issue of incest, whereas sexual advances towards strangers suggests impersonal or anonymous sexual contact. The meaning behind either form of behavior needs to be explored in depth.(48)

3. What type of sexual activity is being exhibited? How consistent is the behavior with the perpetrator's developmental level? Does the activity have any symbolic meaning or any unusual or unconventional aspects to it? Are there any ritualistic elements involved in the sex act? "When the type of sexual activity exhibited by the juvenile is either age-inappropriate, socially inappropriate, or ritualistic, it may signify the use of sex to express nonsexual needs and issues operating in the youth, and the undermining of his psychosexual development."(49) Groth and Loredo warn that in such cases it is essential "to carefully explore the youth's fantasies that accompany such sexual activities."(50)

4. How does sexual contact take place? Does contact occur through mutual agreement or does one person use deception, enticement, or entrapment, intimidation and/or physical force? A careful examination must be made of the interrelationship between sexuality and aggression in the dynamics of the offense. Is sex seen as a way to punish, degrade, embarrass, or hurt another person? Is sex seen as a way of controlling someone, or being in charge? Is aggression itself eroticized into sadistic pleasure? A comprehensive examination of how sexual contact between the individuals involved was achieved can reveal much about the true nature of the perpetrator's motivations, regarding whether or not sex was used to retaliate against someone, compensate for unmet needs, or to diminish conflict over unresolved intrapsychic issues.(51)

5. How consistent is the sexual activity? What is its frequency? How often is it engaged in? How long has this activity been going on? Does it occur as part of broader social interactions and interests, or does it appear to be an excessive preoccupation and persistent act that predominates the juveniles behavior? Does it have a compulsive driven quality? Compulsive, indiscreet, or indiscriminate sexual activity may suggest that the juvenile is experiencing overwhelming stresses or tensions.(52)

6. Is there any evidence of progression in regard to the nature or frequency of the sexual activity? Has it changed in any way over time,

becoming more elaborate or frequent? Has there been a pattern or ritual emerging? Have there been changes in the type of sex act performed or the type of person engaged, and/or the way in which contact was achieved?(53)

7. What is the nature of the juvenile's fantasies that precede or accompany his behavior? The juvenile's fantasies may offer clues to his self-image, comfort or discomfort with his own sexuality, the nature of sexual interests, and the quality of his interpersonal relationships. Moreover, the juvenile's fantasies may clarify the significance of the behavior or its underlying meanings.(54)

8. Are there any distinguishing characteristics about the persons who are the targets of the juvenile's sexual activities? Is attention given to age inappropriate, disadvantaged, handicapped or other more vulnerable victims? Sexual encounters with persons who are not physically, emotionally, socially, intellectually, or psychologically equal to the perpetrator should be considered suspect.(55)

Groth and Loredo caution that juvenile sexual behavior cannot be evaluated separately from the context within which it occurs and the psychological make-up of the actor. They argue that it is important to look not only at the offense, but at the perpetrator's personality development and the context of his current family situation. In assessing a juvenile they suggest three questions to bear in mind. First, what critical developmental events combined to predispose the juvenile to sexual acting out? Second, what current tensions or stresses are operating internally and externally which prompted the offense? Factors to consider are the interpersonal family dynamics, parental attitudes, who has been the juvenile's role models for aggression and sex, and general climate of the family. Finally, practitioners are encouraged to assess to what extent the perpetrator's problem is compounded by other serious psychological disorders, such as mental illness or substance abuse. This will enable them to determine what is the primary diagnosis and what is secondary.(56) (See Appendix III. for Groth's assessment scale.)

Sexual Behavior Clinic.

Abel et. al. rely on several different methods of assessing perpetrators at the Sexual Behavior Clinic. As one would assume they too use

the most popular and oft relied upon assessment method -- the clinical interview. In order to increase the interviews effectiveness it is done in a structured manner using the following guidelines.(57)

1. Number of categories of deviant sexual interest.
2. Order of importance of deviant sexual interests.
3. Number of reported victims of sex crimes by category.
4. Number of completed sex crimes by category.
5. Duration of deviant sexual interests by category.
6. Reported use of sexually deviant fantasies.
7. Personality characteristics.
8. Effects of alcohol and pornography on deviant sexual behavior.
9. Quality of social, assertive, and empathic skills
10. Presence of non-deviant sexual behavior and interest.
11. Degree of force used during the commission of sexual crimes by category.
12. Reported ability to control deviant sexual interests.

The information gathered in the structured interview is checked for validity by comparing the information to police reports and through victim interviews.

Since perpetrators often have distorted cognitions about the appropriateness of their behavior it is important to evaluate their perceptions of the behavior. One way Abel proposes for doing this is to survey adolescents about their most common cognitive distortions, then tabulate and convert their answers (distortions) into a scale. This scale can be administered to offenders and non-offenders to see if a difference exists between the two groups, if a difference in responses is found the scale can be used as an assessment instrument and measure of therapy outcome. Statements revolving around issues, such as children are able to give consent to sexual activities, and the dangerous consequences to the victim of sexual assault are used to provide the practitioner with insight into cognitive distortions.(58)

Abel reports that a quick, valid, reliable, and inexpensive method of assessing various deviant sexual interests is a card sort of sexual interests. Such a card sort is developed by collecting from perpetrators brief phrases that they reported as reflecting their deviant fantasies and that they found to be arousing. The card sort should cover all the DSM III paraphilias, and the perpetrator uses a Libert Scale to rate how arousing the phrases were. Further, he suggests using the McHugh Sexual Knowledge Inventory, Form Y to assess and measure the adolescent's sexual knowledge deficiencies. To assess the perpetrator's social and assertiveness skills he recommends videotaping their responses to structured situations which call for the use of these skills. The tapes can then be rated using a Heterosocial Skills Scale. Last but not least, Abel advocates the use of appropriate neurological tests and the use of psychophysiological assessment tools to measure penile responses directly when a perpetrator is exposed to various deviant stimuli.(59)

University of Washington.

The Juvenile Sex Offender Program is a community based evaluation and treatment program. It is the oldest program of its kind in the country and the conceptual model it uses for assessment and treatment draws from two areas: the first considers the adolescent within a developmental framework, and the second is a family systems model.(60)

A 62 point checklist of criteria relating to the appropriateness of outpatient versus residential treatment has been developed by JSOP's staff. Note "The Juvenile Sex Offender Decision Criteria" is not validated by research and therefore should be considered as a guide only. Moreover, the list is only helpful when used by specialized and experienced sex offender evaluators in conjunction with other clinical data.(61) (See Appendix IV.)

The assessment process at JSOP involves four hours of clinical interviews, including individual and conjoint sessions. Siblings are involved in the assessment and any history of violence in the family and/or sexual abuse is explored. Psychological testing is an integral compent of the process including the Minnesota Multiphasic Personality Index (MMPI) for youths fourteen and up, Rorschach Inkblot Tests, Thematic Apperception Test, Incomplete Sentences Blank, Family Adaptability and Cohesion Scale (FACES) for the family, and the Dyadic Adjustment Scale (DAS) for the parents; along

with exploration of the youth's abstract understanding of the behavior. Crucial in addressing the perpetrator's minimization and denial is the victim's statement and collaborative information from the courts and schools. Other assessment measures include history of delinquency and aggressive behavior at school, at home, and in the neighborhood; academic history; peer relationships; drug and alcohol usage; and evidence of impulsive behavior. Considered in the evaluation process is the age difference between the victim and perpetrator, the number of victims, the duration of the assaultive behavior, the nature of abuse, the type of force employed, evidence of escalation, any history of victimization of the perpetrator, and masturbatory and non-masturbatory fantasies.(62)

CONCLUSION & RECOMMENDATIONS

Conclusion.

A review of the research from various theoretical perspectives reveals certain common themes with implications for assessment and treatment. All theoreticians agree that the onset of deviant or unconventional sexual behavior usually begins around puberty, although related fantasies maybe experienced at a much earlier age. Likewise, there is fairly broad agreement that the unconventional behaviors tend to be chronic throughout the individual's lifetime unless there is early detection and effective intervention. Further, most theoreticians describe the juvenile sex offender as a loner with little skill in negotiating emotionally intimate peer relationships with members of either sex. The juvenile tends to be an underachiever with few outlets for personal expression, deep-seated feelings of inadequacy, and low self-esteem. In addition the juvenile exhibits a diffuse and insecure sense of sexual identity often accompanied by a general mood state of anger depression or emptiness.

Most of the literature point to several risk factors in the making of a juvenile perpetrator, yet no one has identified the definitive causes. These factors include abusive family histories, the development of cognitive distortions, male socialization patterns, and organic biomedical problems. While there are a number of commonalties found in the research, it would also appear that many factors may contribute to sexually deviant behavior. All of these factors must be considered in evaluating the juvenile offender.

The central issue in evaluating an adolescent perpetrator is defining what normative sexual behavior is for them. Determining whether the behavior is situational (predisposing environmental factors), or symptomatic of unresolved issues in psychosexual development becomes the major assessment task. If these two causative elements are ruled out, organic biomedical causes would seem to warrant investigation. An additional assessment area is whether or not the offender has been a victim of sexual assault. Careful attention should be given to the juvenile's fantasies and daydreams to discover other paraphilias or developing paraphilias. Other assessment considerations include the frequency of the behavior, to whom it is directed, the intensity and motivation for the behavior, and the nature of the sexual activity. Note however, the seriousness of the adolescent sex

offender's problem should not be underestimated whether the behavior is a "nuisance" offense or a more aggressive sexual assault.

Each theoretical orientation has its own specialized treatment recommendations which are worth mentioning. Psychodynamic theoreticians recommend helping the juvenile to understand him/herself, to become self observant, improve his/her coping skills, and to learn how to make use of treatment in improving his/her behavior.(63) Biomedical recommendations include the use of drugs or surgical procedures, supplemented by counseling to assist the individual in adapting to a new lifestyle.(64) Situational theoreticians believe the youth must accept the legal consequences of his/her behavior whilst being given support and sexual guidance.(65) Note, Finkelhor's four factor model does not set forth treatment recommendations as such. Instead he feels the model gives some order to the "welter of theories" proposed to account for pedophiliac behavior and that the model can be used to generate theory which will adequately explain the diversity of pedophiliac behavior.(66)

Recommendations.

Evaluating juvenile perpetrators is a difficult and time consuming task. It requires in-depth and detailed personal interviews with the juvenile, his family, and victim, aimed at collecting as broad a data base as possible. The more correlative material that can be obtained and included in the data base the better. Police, court and victim reports, as well as information from family members, school personnel, and other social service agencies should be included in the process. If the presence of organic problems is suspected, the appropriate laboratory tests should be administered. Intelligence and psychological testing, along with physiological monitoring of arousal patterns will broaden the data base available to the clinician. Clinicians and researchers agree the broader the data base available to practitioners the more accurate their assessments.

In addition to in-depth clinical interviews, evaluation and assessment scales should incorporate Groth and Loredo's roster of eight key issues. Other evaluation instruments commonly used are:

Minnesota Multiphasic Personality Inventory (MMPI)
Millon Adolescent Personality Inventory
Thematic Apperception Test
Sentence Completion Tests
Beck Depression Scale
Draw-A-Person
Bender Gestalt Test
Rorschach Ink Blot Test
Sexual Profile and Inventory
Family Adaptablity and Cohesion Evaluation Scale (FACES)
Various Intelligence and Scholastic Tests

Evaluation tools that are devised or selected for use must have a known reliablity and validity and discriminate between perpetrators and non-perpetrators, or be sensitive as a therapy outcome measure.(64) It is further suggested that said tools be devised and/or utilized by a multi-disciplinary team, and that this specially trained team conduct all assessments of suspected adolescent perpetrators.

Until the 1960's psychotherapy dominated the mental health profession. This domination was not conducive to the study of sex offenders as it is not the nature of offenders to be insight oriented. Within the last 20 years social psychology and biological psychiatry have taken an interest in sex offenders, and each discipline has made important contributions to the etiology of sexual deviance. Social psychology has made us more aware of the influence of behavior conditioned by attitudes and experiences in a young boy's world. Biological psychiatry has raised many significant questions, but supplied limited answers, due to the ethical considerations of invasive procedures in human research. Perhaps, the best approach to take in forming a sound paradigm for assessment is a composite one like Finkelhor's which incorporates elements from many perspectives.

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APPENDIX I.

TYPOLOGY OF ADOLESCENT SEXUAL OFFENDERS
Michael O'Brien, Director
PHASE PROGRAM

NIAVE EXPERIMENTERS

1. Tend to be younger adolescents (12-15)
2. No previous history of acting out.
3. Adequate social skills/socialization.
4. Lack of sexual knowledge and experience.
5. Sexual events are isolated, opportunistic, exploratory, situational, non-violent acts with younger children. (3-6)

UNDERSOCIALIZED CHILD EXPLOITERS

1. More extensive patterns of sexual behavior with younger children effected through manipulation, enticement, entrapment, other forms of tricking the victim.
2. Chronic social isolation and poor social skills.
3. No history of other acting out behavior.
4. Inadequacy, insecurity, low self worth predominate.
5. Family disengaged, father distant.

PSUEDO/SOCIALIZED CHILD EXPLOITER

1. Generally older adolescent. (16-18)
2. Feels confident and secure in most settings, exhibiting good social skills.
3. Comfortable but not intimate in peer settings.
4. Little or no history of acting out socially.
5. Usually tests out "normal" on personality measures.
6. Often a victim of physical, sexual or emotional child abuse.
7. Sexual abuse behavior reflects a possible chronic pattern.
8. Offender highly rationalizes behavior, much is characterized as mutual, intimate and non-coersive and little guilt or remorse is experienced.

GROUP INFLUENCED OFFENDERS

1. Sexual offense is an attempt to impress peers, gain peer approval or acceptance or prove oneself in peers presence, (e.g. gang rape, "dare" exposing, bathroom abductions.)
2. Usually no previous history of sexually abusive behaviors or acting out.
3. Personality and family characteristics test "normal", remorse is experienced.

SEXUAL AGGRESSIVES

1. Use of force or violence in commission of sexual assaults against peers, adults or older children.
2. Socially and sexually active with peer group.
3. History of anti-social, acting out behaviors from early childhood.
4. Likely to be using alcohol and/or drugs regularly.
5. Difficulty handling aggressive impulsives.
6. Oversensitive to criticism, tense and anxious, emotionally volitile.
7. Uses primarily denial and projection as defenses.
8. Family characterized by chaos, abuse, violence.

SEXUAL COMPULSIVES

1. Engages in repetitive sexually arousing behavior that becomes compulsive, addictive in nature.
2. Usually hands off behaviors such as voyeurism, obscene phone calls, exhibitionism, fetish burglary.
3. Quiet socially withdrawn.
4. May be studious tending to overachievement and perfectionism.
5. Constant state of tension and anxiety due to hypersensitivity to failure.
6. Inability to express anger appropriately.
7. Emotional constraint and anxiety results in tension-reducing acting out behaviors that involve sexual arousal.
8. Behavior becomes patterned, cyclical and repetitive because it is self-reinforcing.
9. Family system rigidly enmeshed with closed external boundaries. Parents may adhere to rigid and fundamentalist religiousity.

DISTURBED IMPULSIVES

1. Sexual offense is impulsive and signifies acute disturbance of reality testing.
2. Offense may be single, unpredictable, uncharacteristic act or pattern of bizarre and/or ritualistic acts.
3. Offenses reflect malfunction of normal inhibitory mechanisms due to thought disorder caused by psychosis either endigenous or drug induced.

APPENDIH II.

PRECONDITIONS FOR SEXUAL ABUSE
Dr. David Finkelhor

	Level of Explanation	
	Individual	Social/Cultural
Precondition I: Factors Related to Motivation to Sexually Abuse		
Emotional congruence	Arrested development Low Self-esteem Symbolic mastery of trauma Narcissistic identification	Male preference for erotic dominance
Sexual arousal	Arousing childhood experience Traumatic childhood sexual experience Early modeling by others Misattribution of arousal Biologic abnormality	Child pornography Eroticization of children in advertising
Blockage	Oedipal conflict Castration aanxieety Fear of adult females Traumatic experience in adult sexuality Inadequate social skills Marital disturbance	Repressive norms about masturbation, extra-marital sex
Precondition II: Factors Predisposing to Overcoming Internal Inhibitors		
	Impulse disorder Senility Alcohol problem Psychosis Situational stress Failure of incest avoidance mechanism	Social toleration of sexual interaction with children Weak criminal sanctions against offenders Patriarchal prerogatives Social toleration for

		deviance committed under intoxication Child pornography
Precondition III: Factors Predisposing to Overcoming External Inhibitors		
	Mother absent, sick, powerless Mother not close to child Mother dominated by father Social isolation Opportunities to be alone together Sleeping, rooming together	Lack of social supports for for mother Barriers to women's equality Erosion of social networks Ideology of family sanctity
Precondition IV: Factors Predisposing to Overcoming Resistance by Child		
	Emotional insecurity Lack of knowledge Trust between child and offender Coercion	Lack of sex education information for children Social powerlessness

APPENDIX III.

SEX OFFENDER PROGRAM
Dr. Nicholas Groth

Problem Areas

NAME _____

I.D.: _____

Assess the offender's major handicaps or chronic defects in regard to negotiating life demands adaptively. Identify those problem areas which you feel are prominent or characteristic in regard to this inmate.

1. Adversities in Early Life (Unresolved Developmental Traumas):
   - ( ) serious medical illness/accident/handicap
   - ( ) family disruption/separation
   - ( ) death or loss of significant person
   - ( ) physical abuse/neglect (battered child)
   - ( ) sexual victimization/trauma

2. Adjustment Problems:
   - ( ) difficulties in adjusting to school
   - ( ) difficulties in regard to activities of daily living (eg. Managing money, leisure time, etc.)
   - ( ) repetitive difficulties with the law
   - ( ) difficulties in adjusting to work
   - ( ) difficulties in adjusting to military service
   - ( ) difficulties in adjusting to marriage

3. Chronic Emotional Problems:
   - ( ) anger, aggression, hostility, temper
   - ( ) depression, sadness
   - ( ) dependency, passivity
   - ( ) fears insecurities
   - ( ) loneliness, isolation
   - ( ) restlessness, overactive
   - ( ) emptiness, nothing in life has much meaning or interest

4. Difficulties in Social Relationships:
   - ( ) deficient communication skills
   - ( ) deficient empathic ability (failure to put oneself in another's position)
   - ( ) social isolation (difficulty forming or maintaining friendships with age mates)
   - ( ) self-centeredness
   - ( ) difficulties in regard to warmth, trust, mutuality, reciprocity

5. Defects in Self-regard:
   - ( ) poor self-esteem or no self-respect
   - ( ) feelings of inadequacy, vulnerability, and a lack of self-confidence
   - ( ) little capacity for self-observation, insight, or self-appraisal
   - ( ) unrealistic, exaggerated self-confidence, or expectations
   - ( ) immature
   - ( ) impaired/troubled sense of masculinity
   - ( ) poor sense of self-control

6. Sexual Concerns:
   - ( ) lack of sex education/knowledge
   - ( ) unconventional sexual interests/behaviors
   - ( ) unsettled sexual life (confusion or discomfort with aspects of his sexual life)
   - ( ) impersonal sex: "conquests" devoid of attachment or affection

7. Problem Attitudes & Values:
   - ( ) in regard to women
   - ( ) in regard to authority
   - ( ) in regard to sex
   - ( ) in regard to aggression
   - ( ) feelings of persecution/victimization
   - ( ) feelings of ineffectualness/helplessness
   - ( ) other

8. Maladaptive Defenses:
   - ( ) denial
   - ( ) repression
   - ( ) minimization
   - ( ) projection of responsiblity externally
   - ( ) religiosity

9. Compounding Problems:
   - ( ) psychotic/mental illness
   - ( ) organicity ( ) present ( ) suspected
   - ( ) addiction (drug/alcohol)
   - ( ) retardation/low IQ
   - ( ) physical handicap
   - ( ) cultural issues (e.g., langauge barrier)

10. Prognosis:
   - ( ) unmotivated for treatment (uninterested in or resistant to therapy)
   - ( ) unable to make use of therapy
   - ( ) denies offense or feels no need for treatment
   - ( ) prospect for rehabilitation/psychotherapy
     - ( ) negative/poor
     - ( ) guarded/uncertain
     - ( ) fair
     - ( ) positive/good

APPENDIX IV.

Juvenile Sexual Offender
Decision Criteria
Juvenile Sex Offender Program
University of Washington
Seattle, Washington 98195

Instructions: The following criteria are to be used as clinical guidelines in evaluating the juvenile sex offender. The criteria relate both to risk for offending as well as appropriateness of outpatient versus residential treatment.

Code "1" if item is true, "0" if item is not true, and leave blank only if information is missing.

LOW RISK

____ 1. First documented offense, without evidence of a developing pattern.
____ 2. Offender willing to explore offense in a non-defensive manner.
____ 3. Offender acknowledges and understands the negative impact of the offense on victim.
____ 4. Offender willing to accept responsiblity for committing the offense without blaming others or circumstances.
____ 5. Offender is guilty and remorseful because of the negative impact of offense on victim.
____ 6. Offender understands the exploitative nature of the offense and reasons for it wrongfullness.
____ 7. Offender admits to committing entire offense for which he was charged.
____ 8. Offender has healthy attitudes about sexuality.
____ 9. Offender has no history of behavior disorder involving physical aggression.
____ 10. Offender has adequate social adjustment, including presence of a peer support group and participation in peer group activites.
____ 11. Offender has no history of behavioral and/or academic school problems.
____ 12. Parents and guardians acknowledge and understand the negative impact of the offense upon victim.
____ 13. Parents /guardians hold adolescent responsible for offense without externalizing blame onto others or circumstances.
____ 14. Parents/guardians acknowledge adolescent committed entire offense for which he was charged.
____ 15. Family supportive of treatment and willing to become involved in therapy.
____ 16. Family identifies problems within family unit and among members other than the deviant sexual behavior of offender.
____ 17. Offender's family is functional.

MODERATE RISK

_____ 1. Offender has committed two or more documented offenses.
_____ 2. Discontinuation of offense behavior if/when victim showed distress.
_____ 3. Offender resists describing and exploring offense in a non-defensive manner.
_____ 4. Offender does not understand the explotative nature of the offense or reasons for its wrongfulness.
_____ 5. Offender minimizes the negative impact of the offense on victim. (little empathy)
_____ 6. Offender has little or no guilt or remorse because of the negative impact of the offense on victim.
_____ 7. Offender externalizes blame for offense onto others or extraneous circumstances.
_____ 8. Offender minimizes extent of involvement in the offense, admitting to only part of the offense.
_____ 9. Offender resists participation in the evauation without refusing altogether.
_____ 10. Offender has negative self-esteem.
_____ 11. Offender has depressd symptomology.
_____ 12. Offender has unhealthy attitudes about sexuality.
_____ 13. Offender has been a victim of sexual or physical abuse, though this pattern has not been a chronic or repetitive pattern.
_____ 14. Offender has a history of behavior disorder involving physical aggression.
_____ 15. Offender shows poor social adjustment, including isolation from peers and peer group activities.
_____ 16. Offender has history of behavioral and/or academic school problems.
_____ 17. Parents/guardians minimize the negative impact on the victim.
_____ 18. Parents/guardians externalize blame for offense onto others or extraneous circumstances.
_____ 19. Parents/guardians minimize extent of offender's involvement in the offense, holding him responsible for only part of the offense.
_____ 20. Parents/guardians are resistive to particiation in the evaluation without refusing altogether.
_____ 21. Mother or father is a sexual offender.
_____ 22. Mother or father has been a victim of sexual and/or physical abuse.
_____ 23. Family is unable to identify problems within family unit or among family members other than the deviant sexual behavior of offender.
_____ 24. Family is dysfunctional in response to transient situational factors.

HIGH RISK

_____ 1. Offender has been treated for commission of a previous sexual offense.
_____ 2. Offense was predatory.
_____ 3. Offense was ritualistic.
_____ 4. Offense was sophisticated, involving precocious knowledge of sexual behavior.
_____ 5. Offense resulted in physical injury to the victim.
_____ 6. Offense was associated with the use of drugs or alcohol.
_____ 7. Offense involved violence, physical force, use of weapon, or threat to use a weapon.
_____ 8. Continued offense behavior despite victim's expression of distress.

_____ 9. Evidence of progressive increase in the force used to committ repeated offense.
_____ 10. Offender completely refuses to participate in the evaluation.
_____ 11. Offender completely denies the referral offense.
_____ 12. Offender engages in compulsive masturbatory fantasies involving deviant sexuality or offense behavior.
_____ 13. Evidence of thought disorder.
_____ 14. History of firesetting.
_____ 15. History of torturing animals.
_____ 16. History of chronic substance abuse.
_____ 17. Offender has been a victim of chronic and repetitive sexual and/or physical abuse.
_____ 18. Parents/guardians refuse to participate in the evaluation.
_____ 19. Parents/guardians deny that offender committed the offense.
_____ 20. Parents/guardians deny that offender has any psychological problems.
_____ 21. Offender's family unit is chronically dysfunctional.

_____ Code risk for re-offending: (1) low risk, (2) moderate risk, (3) high risk.
_____ Code prognosis/amenability of treatment outcome: (1) good, (2) fair/moderate, (3) poor
_____ Code dispoosition: (1) outpatient family therapy at CDMRC, (2) group therapy CDMRC, (3) individual therapy at CDMRC, (4) group home placement, (5) correctional institution, (6) outpatient treatment referral to facility other than CDMRC

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APPENDIX U.

JUVENILE SEXUAL OFFENDER PROGRAM
University of Washington--Adolescent Clinic

Sexual Offense Assessment Questions

1. Where did you get the idea to do it?
2. What were you thinking (or fantasizing) about when you decided to sexually abuse her/him?
3. How did you pick the victim?
4. Do you think the victim wanted to do it? How do you know?
5. Who else would you have picked if she/he wasn't there?
6. How many times, when did it start, where did it take place?
7. Did the victim cry or ask you to stop? Did that surprise you?
8. What did you do when she/he cried or asked you to stop? How did you stop? Why didn't you do more with the victim?
9. Why didn't you do it more often?
10. What do you think is wrong with this behavior?
11. What do other people think is wrong with this behavior?
12. Why are there laws against it?
13. How did the victim feel? How do you know? What did the victim enjoy about the sexual abuse?
14. What did you do to the victim?
15. Did you have an erection? Ejaculation?
16. What part did you enjoy?
17. How did you make sure the victim would not tell.
18. Who else did you abuse?
19. How often do you masturbate? How old were you when you started?
20. What kind of fantasies do you have when you masturbate?
21. What kind of fantasies do you have when you are just daydreaming?

Sexual Offense Assessment Issues

1. How is the reality of the offense being dealt with, i.e., court, CPS?
2. What is the age difference between the victim and the offender?
3. What is their social/power relationship?
4. What type of sexual activity is exhibited? Does it reflect knowledge that is advanced for the age of the sex offender?
5. Does the sexual activity have any symbolic meaning?
6. Determine degree of denial or minimization.
7. Evaluate for evidence of a developing pattern of deviant sexual behavior, i.e., repetitive nature of offense, fantasies, number of offenses, number of victims.
8. Level of control sex offender has of his/her sex offense behavior.
9. Determine absence or presence of predatory behavior.
10. Evaluate for evidence of increased aggression or victim involvement.

APPENDIX VI.

JUVENILE SEX OFFENDER PROGRAM
University of Washington--Adolescent Clinic

Family Assessment Issues

Sexual Offense and Sexuality

1. History of Sexual or physical abuse in the nuclear and extended family.
2. How sexuality is handled, level of comfort.
3. Each family member's opinion of the sex offense and what they think should be done as a consequence.
4. Level of denial or minimization of the sex offense by each family member.
5. Which family members know about the sex offense, and who does not?
6. If the victim is in the family, how will she/he be protected?
7. Can the parents control the sex offender's access to other potential victims?
8. Who are potential victims in the family?

Family Structure

1. Flexiblity regarding situational and developmental issues.
2. How family decisions are made.
3. How family members disagree and argue.
4. How affection is shown.
5. Who speaks for whom.
6. Who protects whom.
7. Secrets, what the family does not discuss.
8. Level of comfort with individual differences.
9. Recognition of conflicts and differences.
10. How much input from outside of the family is allowed.
11. Strength and consistency of the parent/executive system.
12. How or if the children detour the conflict between the parents.
13. Who else is closely involved with the family, i.e., church, grandparents, etc.
14. Determine intrafamial alliances.
15. Strength and boundaries between generations.
16. Overt and covert family rules.
17. Strength of sibling subsystem.
18. What is not working in the system that is producing sexually abusive behavior.

APPENDIX VII.

CHILD SEXUAL ABUSE
OFFENDER TREATMENT PROGRAM
Human Effective Living Programs, Inc.
185 N. Wabash, Room 12216
Chicago, IL 60601
(312) 332-2792

Evaluation Process

The evaluation process contains the four following components:

I. Psychosocial History - encompassing the following areas:

- Arrest history
- Past arrest history
- Family history
- Marital history
- Health history
- Psychiatric history
- Substance abuse history
- Educational history
- Employment history
- Violence history
- Sex history
- Military history

The client must consent to the release of information from family members and provide the following records:

- Past psychiatric evaluations
- Mental health records
- Military records
- Educational records

In addition, the client must consent to the release of the following to HELP, Inc.:

- Police reports
- "Rap" sheet
- FBI report

II. Psychiatric Examination - addressing the following issues:

- Evidence of any psychopathology
- Potential for violence
- Degree of risk for further molestations
- Suitablity for probation and out-patient program.

- Evaluation of paraphilic fantasies, behaviors and arousal patterns.
- Sexual dysfunction
- Projective testing when indicated

III. Diagnostic Polygraph Examination -

The diagnostic polygraph examination is used to help determine the full extent of paraphilic fantasies, behaviors, and types of involvement in abuse. This information assists in evaluating the client's level of distortion and denial and determining an appropriate course of treatment.

IV. Physical Examination and Medical testing -

A complete physical exam including the following testing:

- Free and weakly bound testosterone level (before 10 a.m.)
- Buccal smear (chromosome analysis)
- EEG with pharyngeal leads (test for temporal lobe epilepsy)
- Blood and urine analysis (tests for drugs and alcohol)
- FSH - LH (follicle stimulating hormone & luteum hormone levels)

Candidates with the following problems will not be considered for the program:

- Offenders with a long or severe history of substance abuse
- Severe psychopathology
- History of violent behavior
- Low or impaired intelligence
- Refusal to plead guilty to all charges in criminal court
- Offenders with misdemeanor charges or terms of probation less than three years

APPENDIX VIII.

GUIDELINES FOR ASSESSING SEXUAL ABUSE IN JUVENILE CASES

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This outline is intended as a general guide for professionals working with juvenile cases that may involve sexual abuse. Juveniles may have been sexually victimized as well as acting out in a sexually aggressive manner. Often a juvenile will be experiencing on-going sexual abuse by an adult that he has no disclosed at the same time he is committing offenses.

Juveniles are often defensive, embarrassed and reluctant to talk about this type of problem. Interviews should include specifics, direct and detailed questions. It is our experience that providing a brief explanation aboout sexual abuse problems and the need for help before asking specific questions is helpful in facilitating disclosure.

The behavioral signs listed below should be seriously questioned, especially when there is no adequate or complete explanation for the juvenile'sbehavior. Some signs are not obvious indicators of a sexual abuse problem alone, but when in combination with other signs may warrant an evaluation.

I. Behavioral Warning Signs

A. Sex-related signs
1. Sexual agression - such as "grab-assing", swearing/intimidation and obvious sexual assaults.
2. Sexual molestation - non-forceable sexual contact with someone roughly 2 or more years younger.
3. Making obscene phone calls or calls that are anonymous and with sexual content.
4. Peeping (voyeurism) - motels, neighbors' bedroom windows, girls bathroom.
5. Exposing genitals to others or consistent public urination or undressing with the purpose of others seeing.
6. Any sexual contact with animals.
7. Involvement with pornography that goes beyond a passing or peer-related interest. Involvement with "hard core" material especially.
8. Sexual picture drawing in pre-pubescent children.
9. Fantasies involving sexual aggression or molestation.
10. Sexual knowledge or persistent imitation of sexual behavior inappropriate for age such as an early adolescent having knowledge of anal intercourse or other uncommon sexual behavior.
11. Sexual nightmares, especially recurring ones.

B. Non-sexual signs
1. Fantasies of violence and destruction.

2. Excessive fighting or fighting with complete loss of control.
3. Any other type of persistent physical or verbal aggression, such as threatening or harassing teachers in school.
4. Cruelty to animals beyond prank stage, such as putting pets in dryers.
5. Compulsive car thefts.
6. Recurrent running away.
7. Compulsive lying or story telling.
8. Repetitive breaking and entering, burglary, shoplifting and stealing, alone without peer pressure and without need for what is taken.
9. Fire setting or fascination with fire.
10. Acting out in a devious or diabolical way, such as cutting phone lines to express anger towards parents, selecting and breaking sentimental items of others.
11. Fantasies about the perfect crime or avoiding detection for major crimes.

II. Personality Characterstics

A. Loner/withdrawn from peers.
B. Keeps anger inside until explosive.
C. Object of ridicule and intimidation by peers.
D. Lack of communication with parents.
E. Identifies with younger children.
F. Feels very inadequate about self.
G. Avoids positive interaction with opposite sex peers.
H. Marked concern regarding sexual identity (or any juvenile identifying self as homosexual).
I. Significaant depression without identifiable stress.
J. Manipulative personality style.

III. Other Warning Signs

A. Dramatic changes in behavior with no identifiable cause, such as sudden and extreme drop in school performance.
B. Avoidance of or fear of being left alone with particular family member, neighboring adult or authority figure (for children age 10 or below).
C. Spending excessive time with younger children (approximately 2 or more years younger).
D. Spending excessive time with persons approximately 2 or more years older.

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